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[JANUARY, 1912.

# THE BRITISH JOURNAL OF DERMATOLOGY

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THE BRITISH  
JOURNAL OF DERMATOLOGY.  
JANUARY, 1912.

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TRICHOPHYTON ROSACEUM.

By ROBT. A. BOLAM, M.D., M.R.C.P.,  
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Newcastle-upon-Tyne.*

In England cases of ringworm due to the *Trichophyton rosaceum* have not been recorded in any great number. Adamson, in 1908 (1), exhibited before the Dermatological Section of the Royal Society of Medicine the first case recognised in this country. Subsequently (1909) Whitfield (2) drew attention to a second case of beard ringworm due to the same parasite. Two further cases giving similar cultures were reported by Haldin Davis (3).

Sabouraud, in his classical work *Les Teignes*, says that this special inoculation in man is very rare, for in seven years, and out of 800 cultures, he only encountered this variety eight times. It is now well recognised, largely as an outcome of his work, that in different countries, or even districts, it may be anticipated that the varieties of fungi found in apparently similar clinical lesions may differ widely. In certain parts of the Continent the rarity of *Trichophyton rosaceum* would seem not to be so pronounced as in France, since Dalla Favera (5) has recorded a number of cases occurring in Parma, and his statistics show that this variety forms something like 4 per cent. of all trichophytons studied in the course of his researches. I have been fortunate enough to meet with a considerable number of cases in the North of England, and to encounter lesions due to this fungus, which show that the early generalisations on their clinical aspects require to some extent revision, as, indeed, Sabouraud has himself pointed out (6). Thus he describes the lesions as epidermic

and follicular, and in both lays stress upon their essentially dry character—"trichophytie sèche de la barbe en forme d'ichthyose pilaire." He compares the manifestations to those of keratosis, and says that ordinarily one observes no traces of any inflammatory processes whatever. In his earliest communications on the subject he went so far as to say that the lesions due to the fungus were invariably absolutely dry, but modified this later, because he had seen two cases with dermic and hypodermic suppuration. Further, he says that this trichophytosis is seen in man only in isolated cases. None of those encountered had been the cause of other infections in the household, and nearly all had seemed to arise spontaneously.

During the past fifteen months I have seen in all sixteen cases of infection by this fungus, and will now briefly state certain points in each case:

(1) R. T—, aet. 37 years. *Tinea barbæ*. Nine weeks' history, beginning by circinate lesion on right side of cheek, later large nodosities, dusky red in color with yellow points, over beard area generally (see Fig. 1).

(2) J. C—, aet. 54 years. *Tinea barbæ*. Three months' duration. Larger part of beard area affected. Dry scaly areas and large pustules alternate. Large-spored ectothrix. Seen a month later, stumps showed endothrix growth with short *carré* segments.

(3) J. Y—, aet. 38 years. *Tinea barbæ*. Small nodules, many with pustular tops. Ecto-endothrix; mycelium thin and spores smallish, rather mosaic in type than arranged in rosary fashion.

(4) C. M—, aet. 5 years. *Tinea circinata*. Large patch, 2 in. in diameter on left wrist, the fringe vesicular, with scaling epiderm within. The whole area looks like the lean of uncooked ham. Abundant large mycelium in scales.

(5) J. M—, aet. 24 years. *Tinea circinata et barbæ*. On glabrous skin of right cheek a small circinate lesion the size of a threepenny-piece, said to have been present from the beginning. Later, spots formed on chin, which now showed violet red sycosiform swellings with a few yellow points of pus. Hair stumps, visibly affected, are of fair length. The mycelium is in the sheath and round the hair, but none found inside at first examination. It is present in pus.

(6) C. G—, aet. 55 years. *Tinea barbæ* of four months' duration. Began like a ringworm; later hard pimples formed. Now shows

scattered flat squamous lesions simulating a coccogenic sycosis in its chronic phase.

(7) G. S.—, aet. 40 years. *Tinea barbæ*. Alternating scaly areas



FIG. 1.—*Tinea barbæ*. *Trichophyton rosaceum*. Kerion type of reaction.



FIG. 2.—*Tinea barbæ*. *Trichophyton rosaceum*. Squamous lesions and large pustules.

with short hair stumps and pustules (Fig. 2). Marked sheath of large spores surrounding hairs, no apparent invasion of hair itself.

(8) B. W.—, aged 27 years. *Tinea barbæ*. Three months' duration. Small red papulo-pustules.

(9) T. W—, jun., aged 25 years. Brother of No. 8. *Tinea barbæ*. A superficial circinate scaly lesion curing rapidly (two weeks). No suppuration or follicular involvement.

(10) B. W—, aged 55 years. Father of Nos. 8 and 9. *Tinea*

*circinata et barbæ*. Circinate lesions on neck, chest, and right arm. Later, pimples on chin, enlarging to small nodules, purple-red in colour with yellow spots here and there (Fig. 3). Hairs break off quite a distance from skin. Ectothrix chains; spores irregular in size and shape. Seen a week later the hairs break off very short and are removed with great difficulty.



FIG. 3.—*Tinea barbae*. *Trichophyton rosaceum*. Diffuse nodular infection.



FIG. 4.—*Tinea barbae*. *Trichophyton rosaceum*.



(11) T. F—, aged 30 years. *Tinea circinata et barbae*. Two small red vesicular areas at the back of right wrist. Beard condition (Fig. 4) began as a surface ringworm; later raised areas showed, some covered with grey-white scale, others kerion-like in appearance. Broken hairs are scarcely visible, showing as black points on the red surface. They are extracted with great difficulty.

(12) W. F—, aged 50 years. Uncle of No. 11. *Tinea circinata*. A single circinate lesion on back of wrist, clearing up when seen.

(13) F. L—, aged 22 years. Brother-in-law of No. 11. *Tinea circinata*. A single circinate lesion on right side of neck. No beard involvement.

(14) G. F—, aged 2½ years. Daughter of No. 11. *Tinea circinata*. Two circinate lesions on temple and cheek. T. F— is accustomed to nurse the child.

(15) S. M—, aged 35 years. *Tinea barbae*. Large papules with yellow top. Condition remained restricted to a few small pimples for at least a month before spreading.

(16) J. H—, aged 30 years. *Tinea circinata et barbae*. Practically whole of beard area and the moustache region covered with fine scales, very like a chronic coccogenic sycosis. There is no pustulation. A few scattered hairs show white and opaque, suggesting infection. The condition started four months ago as a superficial ringworm on right side of chin. There are now circinate lesions on arm and neck.

It is evident from a consideration of these cases that in the north of England, or at all events in the counties of Northumberland and Durham, *Trichophyton rosaceum* is relatively a common cause of lesions of the beard and glabrous skin. I have met with no instance of affection of the scalp or nails, but Dalla Favera (*loc. cit.*) records in his series of six infections, one torpid and one inflammatory lesion of the scalp (two brothers) and one onychomycosis. This frequency is apparently not the result of an epidemic visitation, since the patients presented themselves from various towns and villages in Northumberland and Durham, although naturally the bulk were drawn from Newcastle-upon-Tyne and its suburbs. A radius of forty-five miles covers the area from which cases were seen. Dalla Favera noted that his cases all came from the province of Parma, none from the town itself. My statistics show one fourth from the country and three fourths from the town, a proportion comparable to the relative number of country and

town patients attending the clinic. Coleott Fox has recorded (7) that the common type of parasite in beard cases met with in London is the *Trichophyton violaceum*. In this connection it is interesting to note that out of twenty-three cases of beard ringworm I have examined, twelve proved to be *rosaceum*, and only six *violaceum*, so that the relative frequency of these parasites is widely different in the two districts. The cases noted above show very clearly that all types of reaction to the parasite, from dry scaly patches, like a chronic coecogenic sycosis, to extremely inflammatory lesions of a kerion-like nature may be met with. Erythematous-squamous lesions on the smooth skin as well as definitely vesicular and raised patches have also been encountered, as has been noted in the case of other parasites. In a number of cases the beard lesions were noticed to commence with a superficial ringworm, deeper infection occurring later in the progress of the disease.

The essentially contagious nature of these lesions appears to be well established by the two family groups Nos. 8, 9, 10, and Nos. 11, 12, 13, 14. The virulence of the infection recalls that of the animal ringworms. As may be noticed in infections by other ringworm parasites, no definite deductions can be drawn from the length of the diseased hair-stumps. If the case can be seen early the hairs will be found broken quite a distance from the skin surface; later they break off short, and may eventually, when riddled with the fungi, scarcely be extracted because they are so brittle, and do not project in the least.

Case No. 16 was interesting, since, contrary to the general rule that the moustache area is never affected in *Tinea barbae*, the hairs in the upper lip showed a diffuse infection, verified microscopically and by the growth of a typical culture.

One has not been able to draw any clear deduction from the microscopic appearances of the parasite in the diseased hairs. When seen early the mycelium is definitely ectothrix; and invasion of the hair occurs later. The spore arrangement seems very variable in different cases, but in two instances one has noted that the appearances closely resembled those of a microsporon infection—appearances which were observed by Adamson in his case.

Cultures in nearly all the cases grow readily without contamination on Sabouraud's proof medium; at the end of a week a white *duvet*

is seen which in two weeks will be the size of the head of a shawl pin, and will be showing traces of colour. The tint at first is orange-

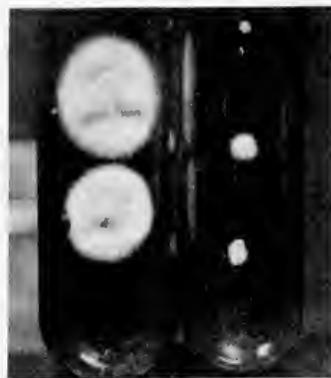


FIG. 5.—*Trichophyton rosaceum*. Tube cultures on Sabouraud's medium, showing various stages of growth.



FIG. 6.—*Trichophyton rosaceum*. Tube cultures Sabouraud's *milieu d'épreuve* (right) and *milieu de conservation* (left).

pink, somewhat like that of the William Allan Richardson rose. A little later the deep face of the culture can be seen to be of the

characteristic deep raspberry colour described by Sabouraud. The culture increases in size, and immediately round the centre becomes depressed, leaving generally a small rounded central button, while

the downy growth becomes raised to a higher level in full rounded folds towards the periphery (Fig. 5).

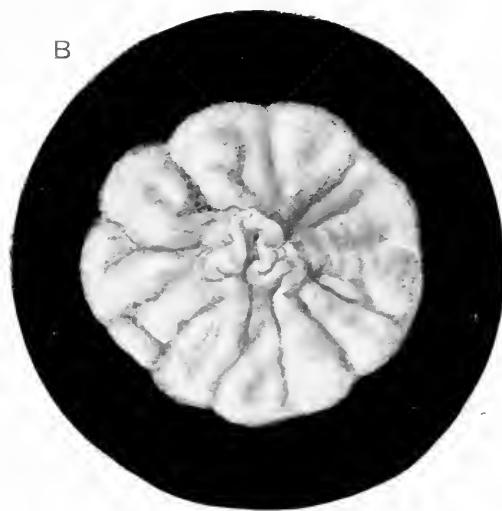
Coloration is very variable in degree, but is usually most intense, neither in the central area nor at the periphery, but in the inter-

A



A. TUBE CULTURES ON SABOURAUD'S MEDIUM SHOWING VARIATIONS  
IN FORM AND DEPTH OF COLOUR.

B



B. CULTURE IN ERLLENMEYER FLASK ON SABOURAUD'S MEDIUM

TO ILLUSTRATE DR. R. BOLAM'S PAPER ON TRICHOPHYTON ROSACEUM



mediate zone. Generally the colour is merely rose, but gradations to a murexide tint can be seen in cultures from the same case placed under slightly different conditions. Elevation of temperature and avoidance of exposure to light seem to make for increased depth of colour. The coloured plate (A) shows a number of tube cultures wherein variation in form and depth of tint are very obvious. In Erlenmeyer flasks, after six or eight weeks, a convoluted culture can constantly be obtained as shown in the coloured plate (B). This is apparently

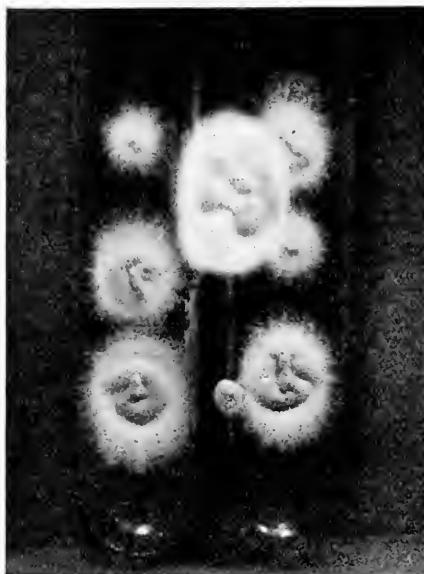


FIG. 7.—*Trichophyton rosaceum*. Tube culture in centre with two cultures of *Trichophyton sulfureum* juxtaposed to show different nature of growth.

quite characteristic and not pleomorphic, because the typical coloured growth can be obtained again from it by sub-culture, and later, after sometimes four months, the usual white pleomorphic down can be seen creeping over its surface. The inky black hue of the deep aspect of the cultures on peptone agar (Fig. 6) (*milieu de conservation*) as described by Sabouraud, is very characteristic, and forms a useful check in any doubtful case.

The origin of this parasite is naturally a matter of great interest, but it must be admitted that, at the moment, nothing very definite can be said on this score. In 1886 Megnin (8) described an affec-

tion of the head and neck of a domestic fowl, and four years later, in association with Duclaux, obtained rose-coloured cultures from similar cases. He maintained that the condition was not a favus, as was suggested by Neumann. In 1893, Sabouraud (9) grew similar cultures from a case of dry trichophytosis of the beard. Two years later Blanchard (10) described apparently the same parasite under the name *Trichophyton Megnini*, and in 1902 Bodin applied the name *Trichophyton roseum* to a similar culture. So late as 1909, Sabouraud (11), in a special article devoted to

the fowl trichophyton in which references to all the previous literature may be found, expressed his belief in the unity of the parasite causing the disease in man and fowl. As the result, however, of further investigation by Suis, Suffran, and himself, he states in his major work, *Les Teignes* (p. 386), that he thinks the two diseases were not rightly identified as caused by the same parasite, and classes the affection of the fowl as a true favus, under the title *Achorion gallinæ*, having a culture differing in important respects from that of the *Trichophyton rosaceum*, while presenting superficial resemblances. He has observed a diffusion of the rose pigment of the achorion culture in the medium, and avers that this is a characteristic so far exclusive to this growth in the whole series of derma-

tophytes. I have found, however, in some experiments not yet completed, that by the use of a suitable sugary medium the pigment of my cultures of *Trichophyton rosaceum* early diffuses into the medium and colours it a rich murexide tint.

Investigation of the contact of my patients with various animals has not resulted in any light on the subject of origin. I have examined horses, dogs, cats, and pigeons where it has been possible that these were sources of infection, but in no instance was any relationship established. Contagion from man to man seems clearly proved by the clinical stories of several cases, and it is usual to find that the beard cases are either accustomed to be shaved by a barber, or, if ordinarily shaving themselves, have noted the outbreak of the disease after a casual visit to a barber, or after having a razor set in such an establishment.

The matter calls for further investigation, and I hope to make a communication at a future date on some points in the mycology and inoculation features of this parasite.

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#### THE VALUE OF MUCH'S GRANULES AND THE ANTI-FORMIN METHOD IN DETERMINING THE AETIOLOGY OF THE SO-CALLED TUBERCULIDES, WITH ESPECIAL REFERENCE TO LUPUS ERYTHEMATOSUS.

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THE tubercular nature of the so-called tuberculides, with the exception of Lupus erythematosus, has been admitted for many

## 14 VALUE OF MUCH'S GRANULES AND THE ANTIFORMIN METHOD.

years, owing to their clinical characteristics, histo-pathological structure, and their frequent occurrence in conjunction with tubercular lesions; but it has been practically impossible to find the tubercle bacillus in scrapings or sections, and animal inoculations have been almost uniformly negative. Thereupon the idea was conceived that these lesions were not tubercular *per se*, but the result of toxins originating in a tubercular lesion situated elsewhere in the body, *i. e.* a tuberculinide, or, as Hallopeau calls it, a *toxi-tuberculinide*.

In addition to the above-named points may be mentioned the use of tuberculin in hypodermic form, or used in the Calmette, von Pirquet, and Moro reactions, but unless we can find a local reaction, a positive reaction only indicates the presence of a tubercular lesion somewhere in the body, and these tests have almost uniformly proven negative in *Lupus erythematosus*.\*

However, the introduction of antiformin by Uhlenrath (1) has greatly lessened the difficulty of finding the tubercle bacillus, and the discovery by Much of what appears to be a form of the tubercle bacillus, that does not take the Ziehl-Neelsen stain, has enabled us to determine the aetiological factor in these conditions where formerly it was practically impossible.

The antiformin treatment of tissues consists in the thorough maceration of the same in a sterile mortar (the author precedes this by sectioning it in a freezing microtome), adding, gradually, a 10-15 per cent. solution of antiformin, until the tissue is in a state of suspension, and it is then placed in an incubator for from eight to twenty-four hours, in which time the tissue should be entirely digested. Alcohol, equalling in amount one fifth ( $\frac{1}{5}$ ) of the solution, is then added and centrifugalised for from one to two hours, and the resulting precipitate smeared on slides. The added alcohol causes a better precipitate by lowering the specific gravity of the solution and causes the material to adhere more firmly to the slides.†

The second light for the elucidation of this problem was given us

\* See author, "Aetiology of *Lupus Erythematosus* with especial Reference to *Tuberculosis*," *Journal of Cutaneous Diseases*, August, 1911.

† Beitzke (15) warns against the possibility of acid-fast bacilli in the water used, so rendering the results inaccurate. Merkel (9) warns against the possibility of bacteria clinging to the walls of the centrifuging tubes, and advises that they be cleaned with a solution of equal parts of concentrated sulphuric acid and Muller's fluid.

FIG. 1.



FIG. 2.





by Much, who, in 1907, reported the finding of a Gram-positive bacillus and granules which were practically constant in lesions that were clinically and pathologically tubercular, occurring in conjunction with, but also without, the ordinary Ziehl-Neelsen staining organism.

Much's (2) conclusions are practically as follows:

- (1) There is a granular form of the tubercle bacillus that is not demonstrable with the Ziehl stain.
- (2) This granular form is virulent.
- (3) It may be the only demonstrable factor in a tubercular organ or lesion.

There is not only an acid-fast form of the tubercle bacillus, but also a non acid-fast form (staining with a modified Gram stain) that may appear as: (1) Solid bacilli; (2) rows of granules; (3) isolated granules.

The investigations of Much and many others have apparently proven his theory, and it is not my intention to go further into the controversy here, except to state that the organism of Much is, as far as known, confined to tubercular conditions, and it also possesses the ability to resist antiformin, a peculiarity only shared by acid-fast bacilli (such as the bacilli of tubercle, lepra, smegma, etc.).

This immunity to antiformin is supposed to be due to the bacillus being encapsulated in a neutral fat capsule, instead of acid fat, as the other antiformin resistant bacteria, and this is the reason that it does not take an acid stain, although Rosenblatt (17) thinks it is due to a loss of the acid-fast membrane, resulting from the breaking down of the tubercle bacillus.

The question as to whether or not the organisms of Much are tubercle bacilli which are dead (Giepel, 16), or degenerated or broken-down tubercle bacilli may be entirely disregarded, since the significance of their presence remains the same. As to whether or not the Gram-staining organisms predominate in numbers over the Ziehl-staining bacillus has been the subject of study by Hatano (18), and he finds Much's organism is present  $1\frac{1}{2}$  to 2 times as often as the acid-fast form; and, while the author has not made any attempt to estimate the comparative numbers thereof, his impression is entirely in accordance with the investigations of Hatano.

The staining method used by Much is a modified Gram stain, of which there are three modifications (see Much, 19), the one used, however, being as follows (Gram II): (1) Methyl violet BN

(saturated alcoholic solution) 10 per cent. solution in 2 per cent. watery solution of carbolic acid. Five minutes heated over the flame or 24-48 hours at room temperature. (2) Lugol's solution 1-5 minutes. (3) Acid nitric (5 per cent.) 1 minute. (4) Acid hydrochlor. (3 per cent.) 10 seconds. (5) Acetone alcohol until the colour ceases to come off the slide. (6) Wash. (7) Bismarck brown (1 per cent.) 1 minute.

However, the desire for a method that would stain both acid-fast bacilli and Much's bacilli and granules simultaneously brought out the combined stain of Weiss (3), which is as follows: (1) Methyl violet solution (as given in Gram II above) 25 per cent., carbol fuchsin 75 per cent. 24-48 hours at room temperature. (2) Lugol's solution 5-20 minutes cold or heating over the flame till it steams. (3) Acid nitric (5 per cent.) 1 minute. (4) Acid hydrochlor. (3 per cent.) 10 seconds. (5) Acetone alcohol until no more colour comes off the slide (control under microscope). (6) Dry with filter paper. (7) Bismarck brown (10 per cent.) 1 minute. (8) Wash and dry.

The results are better if the slides are stained in cold solutions, which should be filtered five or six times before being used, to avoid a precipitate on the slides, and, for the same reason, the slides should be stained in a vertical position. The combined stain should be changed at least every eight days, as the carbol-fuchsin begins to stain poorly about that time.

The organisms of Much appear as sharply defined granules, of varying size and, occasionally, varying shades of dark blue, which, when lying isolated, are surrounded by a fine red border, or they appear as a long, fine, easily bent bacillus containing two to seven granules, the granules being stained as above, while the capsule is coloured a faint red; or they may appear as non-granular bacilli, stained blue with a round body at the ends.

The entire picture of Much's organisms is not unlike that of the Ziehl staining tubercle bacillus with its intra- and extra-capsular granules, but the Gram II of the Weiss stain accentuates the granular element, and in fact it is not possible to distinguish these organisms morphologically from the Ziehl-staining tubercle bacillus.

The author carried out the following line of investigation with the following tissues: (1) Known tubercular tissue—lung, liver, and kidney; (2) *Lupus vulgaris*; (3) *Tuberculosis vera cutis*; (4) *Lupus*

erythematosus; (5) normal skin; the desire being, if possible, to throw some light on the aetiology of *Lupus erythematosus*.

Tissues Nos. 1 and 5 were used as controls, and all tissues were treated in section and also prepared with antiformin, and both sections and smears were stained, partly with carbol-fuchsin and partly with the Weiss double stain.

Such Muhl's organisms as were found in section lay usually where the inflammatory infiltration came in contact with the sub-euticular fat, and they lay both intra- and extra-cellular, especially in the giant-cells, but only in one slide of *Lupus vulgaris* was the author able to verify Arndt's statement, that contrary to the acid-fast bacilli, the Gram-staining organisms occupy the centre of the giant-cell.

The results were as follows: Tissue No. 1 showed Ziehl-staining tubercle bacilli in both section and antiformin-treated smears, and likewise Gram-positive organisms with Gram II and Weiss double-stain.

Tissue No. 2 (*Lupus vulgaris*).—In over sixty sections covering two cases, only one Ziehl-staining tubercle bacillus was found, while Muhl's organisms were found in approximatively every fourth or fifth section, but with the precipitate from antiformin-treated tissue both varieties were found fairly frequently, but a larger proportion of the Gram-positive organisms were present in the form of granulated bacilli.

In all the sections examined of tissue No. 3 (*Tuberculosis vera cutis*) neither Ziehl- nor Gram-staining tubercle bacilli were found in section, but antiformin treatment showed both organisms to be present in very small quantities.

*Lupus erythematosus* (Tissue No. 4).—Tissue from the discoid type of *Lupus erythematosus* was used, and in over sixty sections there were neither Ziehl-staining nor Gram-staining organisms to be found; however, with antiformin-treated smears both organisms were found, that is to say, as expressed by Arndt (12), bacilli possessing all the staining and morphological characteristics of Ziehl-staining tubercle bacilli were found, and also the granulated bacilli of Muhl, the latter greatly predominating. The question as to whether *Lupus erythematosus* is tubercular in view of the above findings is an important one, and although occasional positive reports of local tuberculin

reactions have been published, and at least one positive inoculation (Gongerot, 20) the repeated failure of competent observers to achieve these results must give rise to a question of the accuracy of the observations, and all cases of Lupus erythematosus giving a positive local tuberculin reaction should be sectioned and shown to have no trace of tubercular tissue before the diagnosis is made certain.

That the cases of disseminated Lupus erythematosus have a far clearer connection with tuberculosis than the discoid type is practically certain ; in fact, Sequeira (21) says : " It is usually held that Lupus erythematosus of this type is a tuberculous exanthem, and the clinical evidence is in favour of this," and two of the six cases in which positive findings occurred were of the disseminated type, one of Arndt's with general tuberculosis, and one of Hidaka's, while the other four were of the discoid type, but on the other hand Merkel's case showed no evidence of tubercular organisms, and likewise the two cases of Hidaka. Clinically, everything speaks against the tubercular origin of Lupus erythematosus, at least of the discoid form, the microscopical picture, lack of local tuberculin reaction, and lack of repeated inoculation results ; and the fact that the organisms have only been found in smears, not in tissue, may have some significance.

Arndt (12) says, " Although the germs appear like those of tuberculosis it gives no positive evidence as to the aetiology of Lupus erythematosus since animal experiments are negative" ; and Hidaka (7) expresses himself as follows : " I cannot bring myself to believe, in spite of the finding of tubercle-like bacillus, that Lupus erythematosus is tubercular, in view of all the facts that speak against its tubercular nature," and the author feels that he must agree with above expressed opinion, and would only suggest that possibly we have two conditions under the clinical picture that we describe as Lupus erythematosus, one tubercular in nature, the other not.

Normal skin (No. 5) failed under repeated examinations in section and smear to show any evidence of acid-fast or Gram-staining bacilli, nor were the bacilli mentioned by Hidaka (7) found.

The following table shows the reports to date of the material investigated and the results thereof :

Disease.	Author.	No. of cases.	Section.		Antiformin.		Animal inoculation.
			Ziehl.	Gram.	Ziehl.	Gram.	
<i>Lupus vulgaris</i>	Beas and Ditlevsen (4)	20	1	20	—	—	—
"	Krueger (6)	—	+	—	—	—	—
"	Weiss (personal)	1	—	3	13	—	—
"	Hidaka (7)	11	—	—	—	—	—
"	Merkel (9)	3	—	—	4	11	—
"	Liver (8)	4	—	—	3	—	—
<i>Lupus miliaris</i>	Arndt (10)	1	Few bacilli	Many bacilli	Many bacilli	—	—
"	Dontreleppont (5)	1	Positive	Positive	Positive	Positive	—
Aenitis	Arndt (10)	1	Positive	Positive	Positive	Positive	—
"	Hidaka (7)	1	—	—	—	—	—
Lichen scrofulosorum	Liver (8)	3	Negative	—	1 negative	Negative	—
Serofoloderma	Kuznetzky (11)	1	Negative	—	—	—	—
Erythema induratum	Dontreleppont (5)	1	Positive	Positive	Positive	Positive	—
"	Hidaka (7)	1	—	—	Positive	Positive	—
Lupus pernio	Hidaka (7)	—	—	—	Negative	Positive	—
Lichen nitidus	Arndt (11)	1	—	—	Positive	Positive	Negative
"	Liver (13)	1	—	—	—	—	—
Tuberculosis vera cutis	Liver (8)	2	Negative	—	Positive	Positive	—
<i>Lupus erythematosus</i>	Arndt (12)	2	Negative	Negative	1 negative	2	Negative
"	Hidaka (7)	5	—	—	Positive	3 positive, 2 negative	1 disseminated type
"	Merkel (9)	1	—	—	Negative	2 negative	4-disseminated type
"	Gongorot (20)	—	—	—	—	—	No stain for Much's bacillus

In conclusion the author would say that we have in the antiformin method and the bacillus of Much valuable assistants in the investigation of all tubercular skin-lesions and the so-called tuberculides, and while there can be no positive conclusions drawn as to the aetiology of Lupus erythematosus, it is highly probable that we have opened a gateway by which the much-discussed question can be definitely elucidated.

The author desires to express his sincerest thanks to San. Rat. Dr. Max Joseph and Prof. Ludwig Pick for the many courtesies received from them during the preparation of this article.

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#### ROYAL SOCIETY OF MEDICINE.

##### DERMATOLOGICAL SECTION.

AN Ordinary Meeting, held on Thursday, December 14th, 1911, Sir MALCOLM MORRIS, K.C.V.O., President of the Section, in the Chair.

The PRESIDENT announced that at the meeting of the Council, which had just been held, it had been proposed that, in addition to

the ordinary meetings of the Section on the usual days, there should be a special evening meeting on Thursday, May 16th, when a discussion would be held on "Prurigo, Lichenification and Allied Conditions." It had been suggested that the debate should be opened by Dr. Pringle and himself.

Dr. WILFRID FOX showed a case of *Pityriasis lichenoides chronica* or *Lichen variegatus*. The patient was a woman, aged 49 years. She first came to the out-patient department five years ago complaining of a red and burning face which the exhibitor diagnosed as eczema. The condition at that time was confined to the face and upper part of the neck. There was then very little scaling, no exudation, and no trace of the formation of bullæ. All manner of local treatments were tried for about a year or eighteen months without producing any effect at all, although the skin, especially round the neck, became a little thickened and lichenified, but not to the extent seen at the present time. She was then under the care of Dr. Dawson, and was shown by him before the Section three years ago. About two years ago she returned to St. George's Hospital for treatment, and the exhibitor then found that the condition had progressed considerably. The red scaly area came down on to the chest, ending off very sharply about the top edge of the mammae and on the back about the centre of the shoulder-blades. There were also patches on the buttocks and thighs. They were all of them very much as seen at the present time, that is to say, red pigmented areas considerably infiltrated and lichenified, with adherent scales over the greater part. The pigmentation has increased perhaps in some of them owing to treatment. The patient was perfectly well, only complaining of the intense itching, which made sleep difficult. Various anti-pruritic treatments were tried, but the only thing which appeared to control the irritation was the lencodescent lamp, although after a while this, too, began to lose its power. X-rays had no effect in relieving the irritation, and if anything, rather increased it. From time to time there have been spots which were peculiarly irritable, and which appeared to be the centres from which the irritation started. Some of these had been treated with the actual cautery with considerable benefit, otherwise the only application which appeared to have any beneficial effect was an ointment of menthol and carbolic acid, although of course this

was only palliative. During the last six months there have been a few isolated bullæ appearing, particularly on the neck and shoulders. The face, apparently of its own accord, has improved a good deal, and is now not so red or scaly, and is also less irritable.

Dr. PRINGLE said this patient had been under his care, and his diagnosis was Lichen variegatus. He founded that opinion to a large extent on the ribbon-like arrangement of the lesions. His conception of the disease described by Juliusberg and other German dermatologists as Pityriasis lichenoides was entirely different from the condition presented by the patient. He (Dr. Pringle) thought he had identified two typical examples of it in this country within the last year.

Dr. DAWSON said when he saw the case he showed it as one of Parakeratosis variegata (*Brit. Journ. Derm.*, vol. xx, p. 260). The eruption then occupied much the same position as now. The lesions which Dr. Pringle referred to were better marked down the arm, flat and shiny looking. There was an urticarial margin. At that time Dr. Crocker agreed with the diagnosis.

Dr. PERNET said that in these cases of extreme irritation of the skin, which did not yield to medical treatment or to X rays, a lumbar puncture often gave a good result, at least for a time. Six drachms of the cerebro-spinal fluid should be removed.

Dr. GRAHAM LITTLE said he much regretted he had been unable to bring the case of Parakeratosis variegata which he had announced on the agenda list and which would have formed an excellent comparison case. The patient was a young lady, aged 30 years, and had shown eighteen months previously the beginning of the retiform type of the disease, which had slowly spread until at the present time all the body with the exception of the hands, feet and face was involved.

Dr. GRAHAM LITTLE showed (1) a case of *recurrent Granuloma annulare*. The patient had been seen about five years ago, and the description of his eruption, both from clinical and histological standpoints, was given in the exhibitor's paper on that subject (*Trans. Roy. Soc. of Med.*, July, 1908), under the initials W. S—, case 47. He had been entirely free from the eruption for some two years after that record was made. This had commenced again in the form of small reddish discrete nodules on the wrist and elbow, but especially in the former position. There was at present no ring-formation, but the nodules were exactly like the early nodules seen before in this patient and in the same positions, and the exhibitor had not a doubt that it was the same disease now appearing without ring-formation, which in the earlier attack had been very pronounced. The exhibitor had not previously seen a case of *Granuloma annulare* showing recurrences after a long interval of freedom, and brought this case to show that recurrence was possible.

(2) *A case for diagnosis.* The patient was a child aged about 2 years, somewhat thin and delicate-looking, who eight weeks previously had begun to develop a large number of small hypodermic nodules scattered extensively over the body and numbering, perhaps, fifty. The earliest nodules were the size of a small pea, deep seated, subcutaneous, and the skin over them was not in any way altered. Later, the nodules came nearer the surface and the skin was reddened over them almost as if suppuration were about to take place: one such swelling was incised, but no pus was evacuated. The tumour bled freely. The mother gave a history of the disappearance of some nodules from time to time, and, contrary to expectation, these observations were verified by the exhibitor, who found that some nodules had undoubtedly completely disappeared, notably the one incised, which had been one of the largest, and a fortnight after incision had completely vanished. The nodules were most numerous on the flanks of the body, on the back, the shoulders, the upper areas and forearms, the thighs, legs and feet. The case had been now admitted to the Children's Hospital, Shadwell, and further investigations would be made.

Dr. McDONAGH offered the suggestion that the tumours were subcutaneous rheumatic nodules, the fibrous nodules often met with in children. The mother said they disappeared spontaneously, while others appeared equally quickly.

Dr. DAWSON said one of the lesions looked like Erythema iris, and he would not be surprised to learn that it was Erythema multiforme. He understood the mother to say that some went away and others came up in a day.

Dr. PRINGLE said some of the Fellows, with whom he agreed, thought it was a tubercular condition, and that it corresponded to what had been called by Boeck the "sarcoid" group.

Dr. COLCOTT FOX said he was familiar with the so-called tuberculous gummata in children, and Drs. MacLeod and Ormsby had made a section of one of his cases and found the tubercle bacillus in the walls of tuberculous structure. He was doubtful if Dr. Little's case belonged to this category. As to the name "sarcoid," he did not think it helped them much.

The PRESIDENT expressed his disagreement with the view of Mr. McDonagh that they were rheumatic nodules: the appearance of the latter was different, and sometimes the skin was movable over them.

Dr. J. M. H. MACLEOD showed a culture of the fungus from the hairs affected with "piedra" from British Guiana from the specimens demonstrated at the meeting of the Dermatological Section of the

Royal Society of Medicine in July (*Brit. Journ. Derm.*, 1911, xxiii, p. 255).

Pieces of hair in which a nodule was present were soaked in absolute alcohol for five minutes, and planted on proof agar and incubated at room temperature about ten days afterwards. The culture appeared as a small white knob about the size of a pin's head, with no marked duvet but with a slightly woolly surface. A week later it had reached the size of a split-pea, and had become irregular in outline. In the centre of the culture the colour had changed to a greenish-grey tint. As the culture grew the greenish tinge spread to the edge of it, and the outline became somewhat crenated. Finally, the culture tended to assume a brownish tinge, a little lighter than cooking chocolate.

In broth a flocculent white culture was obtained. This, when subcultivated on proof agar, gave a growth similar to that described above.

A detailed account and photograph of the culture will be published later in the *British Journal of Dermatology*.

Dr. PERNET said that Dr. MacLeod's culture somewhat resembled the culture he (Dr. Pernet) had shown in 1900 to the old Dermatological Society of London.\* But in Dr. Pernet's case the culture was a plate one (proof agar). As to the photograph of Dr. MacLeod's case, it agreed with Dr. Pernet's microscopical description (1900).†

Mr. J. E. R. McDONAGH showed a case of *syphilitic elephantiasis of the scrotum (lymphangitis)*. C. H—, aged 46 years, contracted syphilis in 1882, for which he was treated irregularly with mercury internally. The first recurrence was a papular syphilide on the right palm in 1890, and two small papulo-pustular lesions on the same wrist which had left scars. The next recurrence was a serpiginous syphilide on the left half of the scrotum and another on the gluteal region on the same side in 1900. The patient stated that the scrotal lesion resembled the one on the palm in every way.

A year later the scrotum, first on the affected side, and in time the whole, began to enlarge, but the left side always remained bigger and harder. On examination, 1911, the syphilides had disappeared,

\* Pernet, *Brit. Journ. Derm.*, xiii, 1901, p. 11.

† *Ibid.*, *idem*, xii, 1900, p. 141.

the scrotum was  $28\frac{1}{2}$  in. round, eczematous on the surface. The swelling appeared to be in the skin, which was hard, barely oedematous, and retained its rugose appearance. The testicles could not be felt; and although the skin of the penis was thickened, the organ itself was hidden by the swelling of the scrotum. The folds and inner sides of the thighs were eczematous.

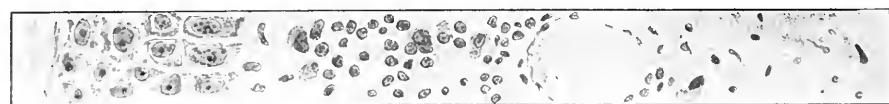
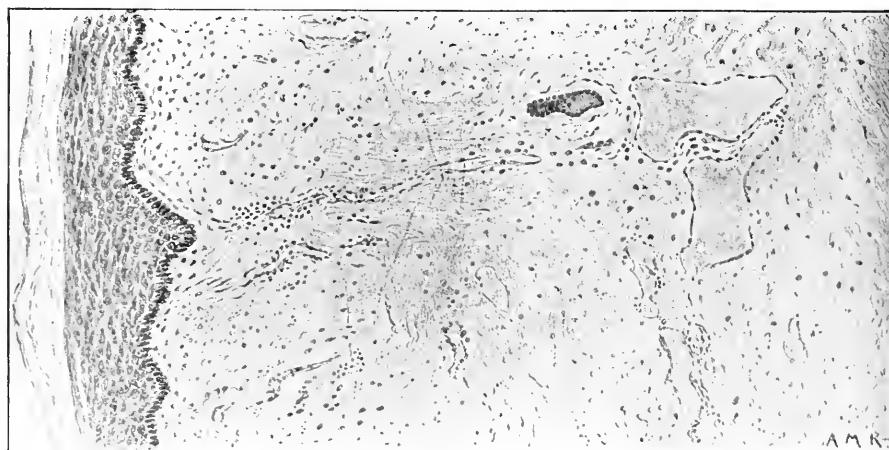
The patient had also chronic superficial glossitis and gave a positive Wassermann's reaction. As a result of thirteen intra-muscular injections of grey oil the circumference of the scrotum measured  $13\frac{1}{2}$  in.,

the skin became softer, the penis did not swell, and the testicles, which appeared normal, could be felt underneath.

Syphilis as a direct cause of elephantiasis has very seldom been described, although we are perfectly familiar with the condition following gummatous and deep-seated mischief as periostitis, in the former being probably due to secondary infection and in the latter to mechanical obstruction.

Syphiloma hypertrophicum diffusum, described by Mracek and Lang, a primary specific elephantiasis, which they reckoned was caused by the fusion of multiple subcutaneous gummatous, does undoubtedly occur, but although the swelling may be diffuse the

subcutaneous nodules are quite distinct. In the case exhibited the swelling was diffuse; no subcutaneous gummata were palpable and no gummata had appeared elsewhere. The swelling started after the appearance of the serpiginous syphilide, which showed that there were specific organisms present in the skin. The syphilide did not ulcerate, therefore a coccal infection could play no part, and the eczema first occurred when the swelling was at its maximum. The exhibitor considered that the swelling was due to a diffuse syphilitic infiltration of the cutis and subcutis



arranged chiefly around the lymphatics—a syphilitic lymphangitis. The way it has improved under treatment supports this view, as the other described conditions behaved in a very refractory manner.

*Histological examination.*—The accompanying drawings explained the condition. The epidermis was practically unchanged except for hyperkeratosis. In the corium were numerous new-formed connective-tissue cells, and in the deeper layers there were wide lymphatic spaces lined with one layer of endothelium; also a great increase of connective fibrous tissue. Around the lymphatics are small round-cells—lymphocytes and a few plasma-cells. The arteries and the veins remained practically unchanged.

Dr. PERNET pointed out that the results in this case showed the great value of grey oil injections, which should not, therefore, be lightly discarded.

Dr. COLCOTT FOX had found that after a certain effect had been produced by the mercury the improvement stopped, which was only natural, as one could not expect fibroid induration to yield to that treatment.

Dr. ADAMSON regarded the case as of interest in that it showed that elephantiasis might occur in syphilis apart from streptococcal infection. It had been suggested that in many cases of syphilitic elephantiasis, especially those of the lower limb associated with ulceration, secondary streptococcal infection might be the cause of the elephantiasis rather than syphilitic lymphangitis, but in this case streptococcal elephantiasis seemed to be excluded.

Dr. PRINGLE said his experience of three cases of syphilitic lymphangitis of the lower limbs confirmed what Dr. Colcott Fox had just said regarding the limitations of treatment. He thought Mr. McDonagh was much to be congratulated on the result so far obtained from the use of grey oil, even although the case was one of short standing only. He asked if any member could bring forward microscopic evidence of the implication of the lymphatics in these cases. Some years ago he looked up the literature, and although people talked glibly enough of "syphilitic lymphangitis," no one, as far as he had ascertained, had established the microscopic characters of the intimate pathological changes.

Mr. McDONAGH, in reply, said he had looked up the literature in connection with the case, and found a record of only one which at all resembled it. Other cases of syphilitic lymphangitis had been described, but they were all secondary to gummatous which had ulcerated, and were due to streptococcal or staphylococcal infection, and they improved but little on administration of mercury, owing to the amount of fibrous tissue formed. Mraecëk's cases were probably diffuse subcutaneous gummatous, and they, again, did not disappear under mercury.

Sir MALCOLM MORRIS and Dr. DORE showed a case of *nævus*.

Nellie L—, aged 8 years.

*Family history.*—Father and mother in good health. Mother had right breast removed two years ago for cancer. Six healthy children.

*Personal history.*—General health good. No illness with exception of measles.

*History of present condition.*—Five weeks after birth a small slightly raised mark, "like perforated cardboard," about the size of a threepenny piece, was noticed above and a little to the inner side of the right nipple.

The mother's attention was first called to the condition after having rubbed the child's chest with camphorated oil, but the oil was only applied once. Iodine and some caustic lotion had been painted on without effect, and the patch had gradually increased in size until the present time.

*Present condition.*—The lesion consisted of a number of small, irregular, smooth, slightly shiny patches of the same colour or a little darker than the normal skin grouped in a linear or herpetiform manner over the second, third and fourth ribs and intercostal spaces from the middle line of the sternum to the anterior axillary fold. The patches were formed by the aggregation of small, hemispherical or somewhat flattened skin-coloured follicular papules, each papule having a minute dotted depression in the centre. In some parts, as at the margin of the areola of the nipple, a few single papules could be seen. There were no subjective symptoms.

The PRESIDENT added that the question was whether it was a new growth or an anomalous form of congenital nævoid growth which had spread in that peculiar way? He invited suggestions with the view to checking its spread. The classical case of nævus published by Sir Jonathan Hutchinson was more warty and streaky than this. He would endeavour to get a biopsy. By daylight the older parts were seen to have a yellowish tinge. He had thought of the possibility that it might be congenital xanthoma.

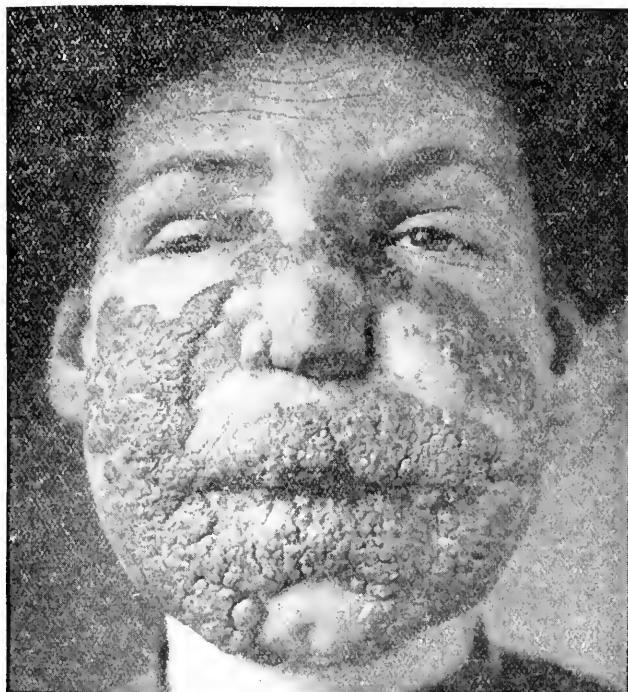
Dr. ADAMSON regarded it as a unilateral linear nævus made up probably of sebaceous glands. He had recently exhibited cases of pigmentary linear nævus and a case of vascular and warty linear nævus, and had now under his care at the hospital a case of hairy linear nævus made up of pilo-sebaceous follicles. A linear nævus was generally a warty growth, but it might be derived from any of the structures or appendages of the epidermis.

Dr. MACLEOD said that he considered the affection to be a form of unilateral nævus. It appeared to develop around the follicles and was possibly of sebaceous gland origin, but it might be composed of cells similar to ordinary soft nævi, and he was unable to give any definite opinion with regard to its minute structure.

Mr. McDONAGH regarded it as a nævus, probably of the sebaceous gland type.

Dr. SEQUEIRA showed (1) a case of *Lupus vulgaris in a syphilitic subject*. The patient, a married woman, aged 36 years, has been under Dr. Sequeira's care for nearly three years. She has a brother who has been in the Victoria Park Hospital suffering from phthisis. She has had two miscarriages and has one child alive and in good health. Seven years ago she noticed that her voice became husky, and that she had some pain in the throat on swallowing. There was also some discharge from the nasal cavity and this was scraped. Four years ago a "pimple" appeared on the left side of the nose a little below the inner canthus, and a large number of nodules developed with great rapidity over the cheeks, nose, and the upper and lower lips.

The present condition is well shown in the accompanying photograph. The nodular masses were soft and easily broke down, discharging a thin yellowish pus. The mucous membranes of the lips were involved, but there was no extension on to the gums. There was a small ovoid ulcer with granular surface in the middle line of the palate and well-marked lupoid infiltration of the larynx. It was difficult to see how much of the larynx was involved, as the pain on opening the mouth prevented a thorough examination.



The patient was in the London Hospital in 1908, and the rapidity of the spread of the disease with the history of miscarriages suggested a syphilitic origin. She was treated with mercurial inunction and improved considerably, the ulcerated surfaces healed, but the nodular lesions persisted. Atoxyl was then tried and some further amelioration was observed. She then ceased to attend for some months, and on her return to the Hospital the areas were more extensive and the ulceration had again appeared. Treatment by mercury and iodides proved of little service, and the patient steadily got worse. In

February, 1911, she was again admitted to the Hospital. She had then a strongly positive Wassermann reaction (+++). She received two injections of salvarsan (0.5 intra-venously and 0.5 intra-muscularly). There was again definite improvement, but the nodular lesions did not clear up. She gave a positive von Pirquet reaction and the diagnosis of tubercle and syphilis was evident. In the spring of this year nodules appeared upon the front of the right forearm, and one of these was excised and sent to Dr. Stanley Griffith at

Cambridge. He has since reported that he was able to obtain the tubercle bacillus of the bovine type from the material sent.

The case is of interest in the rapid development of the lupus and its tendency to rapid disintegration, and the fact that the presence of both syphilis and tubercle has been proved by clinical tests and by inoculation.

Dr. PERNET said that in his experience this class of case did not do well on specific treatment, as far as the *Lupus vulgaris* lesions themselves were concerned; indeed, it seemed to aggravate them.

(2) *A section from the case of extensive ringworm with granulomatous formation exhibited at the last meeting.* The section showed characteristic granulomatous tissue with a few giant-cells. Strands of mycelium in parts showing bead-like segmentation, and conidia bodies stained by the Weigert-Grum stain were present in the granulation-tissue.

(3) *A culture of Achorion Quinckeum (mouse-fur),* obtained from a little girl, aged 5 years. The lesions were minute yellowish cups, six in number, grouped upon the outer surface of the right leg. Each cup was about one-tenth of an inch in diameter, and showed characteristic felt-work of mycelium. The cultures grew rapidly on the maltose agar medium, and presented a circular, white downy appearance closely resembling the cultures of the *Microsporon Audouinii*. The scalp was unaffected. The source of the infection was not traced.

Mr. ARTHUR SHILLITOE showed (1) *a case of syphilis.* The patient was a young man, aged 27 years, who exposed himself to infection 1½ years ago, but did not appear to have contracted syphilis. Last April he married. Mr. Shillitoe saw him with some indurated œdema of the lower part of the scrotum on August 21st. He could not detect any sore. The patient also had a general erythematous eruption and a specific throat. Both these conditions cleared up, but on November 1st he suddenly developed a psoriasis-like eruption on the flexor surfaces of the arms, on the buttocks, and behind the knees. That had now improved. The Wassermann reaction was positive. The wife is some months pregnant, but up to the present time shows no evidence of having been infected. Her blood has been examined by the Wassermann reaction, but at the time of the meeting the result was not known.

Dr. PERNET did not consider the case had any connection with psoriasis. He regarded it as simply syphilis.

(2) *General small lichenoid syphilide.* The patient was a young man, whom he brought to show how long such small lichenoid eruptions would persist in spite of treatment. This man contracted syphilis early in May, and since the end of June he has been treated by injections of calomel, but nothing seemed to touch the eruption.

It was very extensive indeed, and the Wassermann reaction was positive. There had not been any particular local treatment. The hair was now falling off. There was some improvement, but it was a very obstinate case.

Dr. STOWERS suggested that calomel vapour baths would be a useful addition to the treatment of this case, he having seen good results follow this method in similar conditions.

Dr. PERNET said some cases of this kind were very resistant to treatment, even to "606," but he agreed with Dr. Stowers that calomel baths were often very helpful.

Dr. WINKELRIED WILLIAMS showed (1) a case of *Acne agminata*. At first he diagnosed *Acne vulgaris*, but as he watched the case the amount of scarring was disproportionately great, and the grouping of the lesions below the eyes, despite wide-spread comedones, made him wonder whether it was not *Acne agminata*. There was no tubercular history, and the patient had only had the condition about five months. The eruption of most of the lesions was simultaneous, and they similarly involuted, most of them without pustulation, leaving scars larger than the lesions.

Dr. PERNET did not consider that the case belonged to the category of *Acne agminata*. He had seen the cases of *Acne agminata* described by the late Dr. Radcliffe-Crocker, and examined them histologically.\*

(2) *A peculiar nævus*. The patient was a girl who was sent to him a year ago as congenital keloid, but when he saw the case the head was covered with eczema, and afterwards there appeared an extensive unpigmented nævus. When the child was born there was a lesion caused by pressure of forceps, and that might have led to the development of the nævus. It was not growing. The nævus was oblong, parallelogram-shaped, and extended from the middle of the forehead obliquely outwards over the scalp.

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#### INTERNATIONAL CONGRESS OF DERMATOLOGY AND SYPHILOGRAPHY, ROME, 1912.

THE Committee of Organisation of the Seventh International Congress of Dermatology and of Syphilography have fixed as the date of the Congress April 8th to 13th, 1912, immediately before the International Congress against Tuberculosis, which will take place from April 14th to 20th. As the final programme will be printed in the second half of January it will be still possible to insert fresh communications until the fifteenth of the month.

\* H. Radcliffe-Crocker's 3rd edition, vol. ii, p. 1097. See Fig. 79.

**NATIONAL ASSOCIATION FOR THE PREVENTION OF CONSUMPTION.**

THE Association is actively engaged in forming a library and bureau for the collection of all matters relating to pulmonary tuberculosis from every point of view, and in all countries. It is intended that such information shall be available not only to members of the medical profession but to the public at large. Valuable assistance would be rendered if medical officers of health, school medical officers, and medical superintendents or secretaries of hospitals, sanatoria, tuberculosis dispensaries, and open-air schools would kindly place the Association on their distribution list in respect of annual reports or other documents bearing on the question of consumption. Books, pamphlets and reprints of articles from physicians and social workers in general would also be gladly received by Dr. J. J. Perkins, Hon. Secretary, 20, Hanover Square, W.

**CURRENT LITERATURE.**

**ARSENICISMUS WITH RETICULAR MELANODERMA.** P. L. BOSELLINI. (*Archiv f. Derm. u. Syph.*, 1911, Bd. cix, p. 37.)

THIS report is based on two cases, both females, aged respectively 14 and 21 years. The younger patient had taken arsenic for anaemia for two months, and the elder had taken it in interrupted courses for three years. The eruption was accompanied by an erythema on the limbs and trunk and hyperkeratosis of the palms and soles in both cases.

By watching the cases carefully Bosellini was able to observe that the pigmentation, which in one case resembled that of Pityriasis versicolor, was secondary to an inflammatory process. He draws attention to the similarity existing between this form and that described as occurring in syphilis and tuberculosis.

A. W.

**A CONTRIBUTION TO THE KNOWLEDGE OF CALCAREOUS EPITHELIOMA OF THE SKIN.** KOTA MURAKAMI. (*Archiv f. Derm. u. Syph.*, 1911, Bd. cix, p. 51.)

THE tumours on which this paper is based came from four patients: Case 1 was a tumour of the lumbar region in a boy, aged 16 years. Case 2 came from the lower part of the back of a man, aged 60 years. Case 3 came from the back in the neighbourhood of the angle of the left scapula of a woman, aged 60 years. Case 4 came from the subcutaneous tissue of the upper margin of the orbit of a girl, aged 8 years. The tumours, which exhibited slight differences between them, consisted mainly of lobed growths containing horny pearls and masses of calcareous material, surrounded by fibrous tissue containing giant-cells. The surrounding fibrous tissue and some of the epithelial structure had undergone hyaline degeneration.

From a careful study Murakami comes to the conclusion that the origin of the tumours in Cases 1 and 4 is certainly sebaceous glands or rudiments (Anlage) of sebaceous glands. He thinks it probable that Cases 2 and 3 are also of the same nature.

After discussing the nomenclature of these tumours Murakami comes to the conclusion that "Calcareous Epitheliomas" ("Verkalkten Epitheliomen") is the

best name, it being understood that the term "epithelioma" is not used to imply any malignancy.

A. W.

**ON SOME TRANSFORMATION FORMS OF PLASMA-CELLS.**

J. E. R. McDONAGH. (*Archiv f. Derm. u. Syph.*, 1911, cix, p. 441.)

THIS is a short note to show the different forms that are assumed by plasma-cells in their regression.

The first case was one of a sarcomatous ulcer on the right hip (round-celled sarcoma). In this case the plasma-cells are three to four times the usual size, and the nucleus occupies most of the cell-body. The protoplasm stains weakly, and is granular. In some cases the cell-membrane has disappeared and the granules lie loose outside the cell. The nucleus stains feebly but shows a strongly staining nucleolus. The plasma-cells may be traced through gradations into sarcoma-cells. McDonagh derives the sarcoma-cells, therefore, from plasma-cells, and the latter from lymphocytes.

The second case was one of Lymphodermia perniciosa. In this case the plasma-cells break up freely so that the nuclei are often found surrounded by masses of granules. The third case was one of papulo-tuberular syphilide. Here the cells run together as if molten, and produce hyaline masses containing nuclei. In some instances the cytoplasm is vacuolated and has a spongy appearance. No chromatin or nucleolus is visible in the nucleus. In some cases the cells may form a fibrous tissue, but in the part illustrated this is hindered by the fact that the plasma-cells are undergoing solution.

A. W.

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**CORRESPONDENCE.**

*To the Editor of the BRITISH JOURNAL OF DERMATOLOGY.*

DEAR SIR,—As to the aetiology of leprosy, the letter of Dr. de Verteuil in the last issue of the Journal is to the point. The same idea must have suggested itself to anyone who has been to Gibraltar. Tangier must also be taken into consideration.

On the other hand, leprosy in Gibraltar proper appears to be very rare, as stated by Dr. William Turner in his note published in the September number of the Journal, a condition of affairs due no doubt to British hygiene, cleanliness and supervision.

Dr. Turner said that no case of leprosy had occurred among the inhabitants of Gibraltar for thirty years to his knowledge. In my report on Leprosy in the British Empire (Fifth International Congress of Dermatology, Berlin, *Trans.*, 1904, vol. i, p. 18), I find Colonel J. McNamara, Principal Medical Officer at Gibraltar, kindly informed me in reply to my request for details that Major W. H. Horrocks, R.A.M.C. had only been able to find the records of one case of leprosy, which dated back to 1890. The patient was a Maltese, who had been in Spain, France, and North Africa. It was suggested the man had become infected in North Africa. I have no further details, but the foregoing may be of some interest to Dr. Turner.

I am, yours truly,

GEORGE PERNET, M.D.

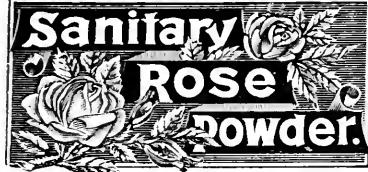
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